Secondly, can the outcome of chronic anterior uveitis be predicted from the subtype of juvenile chronic arthritis with which it is associated? In other words, is there any sense in screening the subtypes at different frequencies? There is no doubt that the risk of developing chronic anterior uveitis varies with the subtype of juvenile chronic arthritis. Children with systemic onset juvenile chronic arthritis, rheumatoid factor positive polyarthritis, or spondyloarthritis are unlikely to develop chronic anterior uveitis, and as such probably do not warrant screening. However, there is little evidence to suggest that the outcome of the uveitis is related to the subtype of the arthritis. The risk of chronic anterior uveitis should determine who is enrolled in a screening programme, but the frequency of screening should be independent of the risk of chronic anterior uveitis and be based instead on the natural history of the disease.³

M Rawes's assertion that joint aspiration for septic arthritis is associated with a poorer outcome because it results in late referral to orthopaedic surgeons is debatable.¹ An urgent diagnostic arthrocentesis may not only decompress the joint space but may also allow the initial choice of broad spectrum antibiotics to be modified appropriately in the light of microbiological evidence.⁴ Rawes also implies that arthrotomy and joint washout is the treatment of choice for all forms of septic arthritis in children. There is evidence that some forms of septic arthritis may be successfully treated with a single aspiration of the affected joint and appropriate antibiotic cover, raising the possibility that arthrotomy may be sometimes an unnecessarily invasive surgical procedure.⁵ For further informed debate on this important subject, Wilson and Di Paola's call for a multicentre, controlled, prospective clinical trial of treatment in childhood septic arthritis must be answered.⁶

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Rationing: the case for "muddling through elegantly"

EDITOR,—Chris Ham's editorial on health care rationing misrepresents my position on the issue. He suggests that I subscribe to an approach to rationing by muddling through. My actual position is rather more subtle, hence the description "muddling through elegantly." I emphasise "elegantly" because I do not seek to defend the previous closed system, in which resource allocation decisions were often dressed up as clinical ones and hidden from public scrutiny.

I, too, support greater transparency in decision making, but I don't believe discussions about rationing can be tackled effectively or sensibly in a national debate. Muddling through elegantly starts from the premise that rationing will always be a messy affair. The choice confronting policy makers is as follows: does the inevitability of micro level rationing mean a continuation of the kind of

diffuse, largely invisible, kind of rationing that has characterised the NHS, or is there a need to find ways of holding clinicians to account for what they do and insist on greater transparency in their decision making between them and their patients? The first option is an example of muddling through; the second is an example of muddling through elegantly. I subscribe to the second, which has also been described as an approach based on "pragmatic sensibility."²

Wisely, the United Kingdom has not followed other countries' example in producing a national framework to guide rationing decisions within the NHS. Being too explicit about complex, multifaceted decisions is not axiomatically desirable. It may "result in insensitivity to the complexity of clinical care, to the rapidly changing character of medical knowledge, to the uncertainties of the care process, and to the wide range of situations, needs, and preferences of patients."³

Britain already has the most centralised governmental system in Europe. We need less and better government, not more and worse government. A national debate that seeks to explore the complexity of the rationing issue amounts to a contradiction in terms. A national debate, aided by a media whose interest in health care stops at waiting lists and hospital and bed closures, is likely only to trivialise the issue and allow professionals to evade their responsibilities to individuals and groups. Furthermore, an exclusive focus on rationing diverts attention from another difficult policy problem, which is the need to be much more rigorous in the search for cost effective health care.

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Setting priorities for surgical waiting lists

EDITOR,—The House of Commons health committee's report *Priority Setting in the NHS: Purchasing* recommends the refinement of targets for waiting times.¹ Now that the worst excesses of waiting have been removed in most areas the time has come to think more deeply about measures of need for surgery.

Waiting lists have been discussed by Culyer and Cullis.² We have ordered waiting lists in Salisbury by using the following variables: progress of disease, pain or distress, disability or dependence on others, interference of disease with normal occupation, and time spent waiting on list. The first four variables must be improvable by surgery. Each variable is scored 0-4. Patients are assessed in outpatient clinics, and default scores typical for the condition are applied, though these may be adjusted for the individual patient. An overall score (using weighting factors derived from a study of priority among 75 patients assessed by both general practitioners and consultants) is generated.

Purchasers can now be much more sophisticated about their requirements for waiting lists; they can state that they do not, for example, want any patients waiting on a list if they have pain uncontrolled by strong analgesics, are dependent on others, or are out of work (in addition to the usual time factor), or they can declare a maximum aggregate score (weighted sums of squares).

We have incorporated this scoring system into software for a system that manages waiting lists (Delian Medical Systems, Princes Risborough)

and that also monitors the resources required to treat patients on the lists. This data base now contributes to the setting of priorities and targets to ensure that patients with the greatest need are treated first and that purchasers and providers are informed about the resource implications of treating patients on waiting lists. Both purchasers and providers can now inspect their lists and discuss, with full facts at their disposal, who should be offered treatment first.

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Homoeopaths and chiropractors are sceptical about immunisation

EDITOR,—Richard J Roberts and colleagues point to several reasons for disappointingly poor response to immunisation campaigns.¹ A further, not well recognised cause is the attitude of some complementary practitioners. One British survey noted that the commonest reason for refusal to immunise was homoeopathy.² Interesting new data come from Austria, where the practice of homoeopathy by non-medically qualified people is illegal. A recent survey shows that only 23% of Austrian homoeopaths believe that immunisation is important.³ The problem also extends to other complementary practices. One third of American chiropractors believe that there is no scientific proof that immunisation prevents disease and that it causes more illness than it prevents.⁴

These cumulative data imply that some complementary practitioners (doctors and non-doctors) put their patients at risk through their attitude towards immunisation. This issue needs to be considered when the safety of complementary medicine and its practitioners is discussed.

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Reflex sympathetic dystrophy

May be accompanied by involuntary movements

EDITOR,—In the review of reflex sympathetic dystrophy we were particularly interested in figure 3, showing reflex sympathetic dystrophy of the left foot.¹ The affected foot has a curious, intuned dystonic posture; readers are not told whether this was a constant feature. Involuntary movements, including tremor, spasms, and

dystonia, are not uncommonly seen in the affected limbs of patients with reflex sympathetic dystrophy²⁻⁴—a fact not mentioned in the review.

The appearance of the limbs in the author's figure 3 is similar to that of patients with the causalgia-dystonia syndrome (figure).⁵ Such patients have fixed dystonic posturing of the affected limb in addition to the other typical features of reflex sympathetic dystrophy. The dystonia either occurs at the same time as or follows the symptoms of causalgia.¹¹ Interestingly, the patient shown in figure 3 in the review is said to have had similar symptoms in the other foot and in one hand previously. This was also seen in the patients we described previously, in whom the causalgia and dystonia would spread from the affected limb to other limbs.⁵ Such spread suggests that central mechanisms play a part in the pathogenesis of the syndrome.⁵

It is important, for two reasons, to recognise this subset of patients with reflex sympathetic dystrophy who have additional dystonia or other movement disorders. Firstly, from the prognostic point of view, in our experience these patients seem refractory to most forms of conventional treatment for this condition.⁵ Secondly, because such dystonic muscle spasms may dominate the clinical presentation these patients may be referred to many different specialists, including orthopaedic surgeons, rheumatologists, neurologists, and physiotherapists, who need to know the different manifestations of this difficult condition.

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Has been renamed complex regional pain syndrome

EDITOR,—Elisabeth Paice's review of reflex sympathetic dystrophy¹ omits to refer to two important recent publications. In the second edition of its taxonomy on pain the International Association for the Study of Pain has replaced the term reflex sympathetic dystrophy with a new term, complex regional pain syndrome type I.² Sympathetic involvement and dystrophy do not occur in every case of reflex sympathetic dystrophy. Causalgia becomes complex regional pain syndrome type II. Pain that is maintained sympathetically may coexist with either of these syndromes. The diagnostic criteria for complex regional pain syndrome type I are ((b) to (d) must be satisfied): (a) the presence of an initiating noxious event or a cause of immobilisation; (b) continuing pain, allodynia, or hyperalgesia, with the pain disproportionate to any inciting event; (c) evidence at some time of oedema, changes in skin blood flow, or abnormal sudomotor activity in the region of the pain; (d) the diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction.

Jadad *et al* conducted a systematic review of the literature and a randomised controlled trial of the use of intravenous regional sympathetic blockade for pain relief in so called reflex sympathetic dystrophy.³ Neither element of their report sup-

ports the use of intravenous regional blocks with guanethidine in this condition. In the light of this finding Paice is right to call for a critical evaluation of all the treatments used to manage reflex sympathetic dystrophy.

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Leeds students were angry with the university, not each other

EDITOR,—In Luisa Dillner's news item about the medical students in Leeds who had to resit a multiple choice paper in their final examinations, Frances Ledgard, the university's information officer, is quoted as saying, "The students...are angry and upset with each other—those that had seen the paper were cross with the ones that complained."¹ This is both inaccurate and disingenuous. The students were not angry with each other but were united in their annoyance with the medical school and university authorities at the error. This solidarity was shown by the fact that the students themselves arranged a meeting to discuss the problem.

Ms Ledgard's statement is disingenuous because it implies that some of the students had cheated or were otherwise to blame. This is untrue, and the university has accepted full liability for the mistake. Aside from the factual inaccuracy, I find it insensitive that Ms Ledgard should obliquely suggest underhand behaviour by the students. Enough anxiety had already been caused by the university, with students having to resit this difficult paper.

Secondly, the provision of multiple choice questions as a learning tool is well recognised. The provision of past questions from these papers is analogous to that of past essay papers and should be routine. The events at Leeds should provide the stimulus for a much needed re-evaluation of the standard and structure of the final year exam in medicine, as pointed out by Andy Smith, the students' representative.

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New equities of information in an electronic age

EDITOR,—Christopher Zielinski's editorial "New equities of information in an electronic age," is an excellent summary of the many problems faced by developing countries in receiving and supplying health information. Since 1977 the Appropriate Health Resources and Technologies Action Group (AHRTAG) has worked with partners in developing countries to disseminate relevant and accurate information on health and to develop information systems to meet local needs. The group is an independent non-government organisation and has no corporate links with commercial providers of information.

AHRTAG publishes four newsletters—on child health, HIV infection and AIDS, disability, and

primary health care management—and distributes them free in the developing world. The newsletters seek to balance biomedical information with a community perspective and provide a forum for readers to exchange experiences and views. Authors are from, or have worked in, developing countries. Subjects tackled range from dealing with infectious diseases, through changing community attitudes about disability and HIV infection, to developing strategies for management and health education.

AHRTAG's partners in developing countries translate or adapt the newsletters for regional distribution. In 1994 the newsletters had a total circulation of 600 000 in 11 languages and an estimated three million readers worldwide.

AHRTAG's resource centre in London houses a unique collection of over 19 000 books, journals, training manuals, slides, and videos focusing on practical aspects of primary health care. The emphasis is on material from developing countries. Few of these resources reach medical or academic libraries. AHRTAG has continued to develop systems to make information in the resource centre more accessible. Bibliographic databases can be an effective way of improving the flow of information to and from developing countries. AHRTAG is working to make its databases more easily accessible through increased circulation of the printed list of its resources and through the Internet. To be successful, however, this depends on well developed communications systems, which are often unavailable in areas where information needs are greatest. Therefore we are working with our partner organisations to establish their own resource centres, based on local needs.

Like all charities, AHRTAG must raise funds to cover the ever increasing demands for its services. Yet many vital areas of its work, including the resource centre and the new child health newsletter, *Child Health Dialogue*, are currently underfunded. Equity in information requires that organisations such as AHRTAG and its partners in developing countries receive the relatively modest amounts of funding needed to develop new channels of information. Readers who would like further information on AHRTAG and its work should write to me.

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Asymptomatic retinal haemorrhage is common at altitude

EDITOR,—In their article on mountaineering medicine Christine H D A'Court and colleagues neglect to discuss one of the commonest medical disorders at altitude; retinal haemorrhage.¹ This is surprising since macular haemorrhage is listed as having affected one member of their team and was probably detected only after the subject complained of central visual field loss.

Retinal haemorrhage at altitude is usually symptomless and has been studied in detail only relatively recently. Funduscopy performed on expeditions over 6000 m has shown an incidence of 36% in 39 subjects climbing Mount McKinley,² 29% in 14 army recruits climbing in Nepal,³ and 29% in 14 subjects and 20% in 30 subjects climbing Mount Everest.⁴ Retinal haemorrhage at altitude also occurs as a result of severe cerebral oedema,⁵ but little is known of the aetiology of the condition when it develops spontaneously. Links have been made to heavy exercise at altitude^{2,3} and use of non-steroidal anti-inflammatory drugs.⁴